



















Kopfschmerzprotokoll

Name: _____

Geburtsdatum: _____

| | | | | | | | | | | | | | | |
|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|
| Wochentag/ Datum | | | | | | | | | | | | | | |
| Stärke (0-10) | | | | | | | | | | | | | | |
| Uhrzeit Von-bis | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Lokalisation |  links |  rechts |  links |  rechts |  links |  rechts |  links |  rechts |  links |  rechts |  links |  rechts |  links |  rechts |
| Übelkeit Ja/nein | | | | | | | | | | | | | | |
| Erbrechen Ja/nein | | | | | | | | | | | | | | |
| Was hast Du heute wegen den Kopfschmerzen unterbrochen? | | | | | | | | | | | | | | |
| Medikamente | | | | | | | | | | | | | | |
| Wie war Dein Tag? |  | | | | | | | | | | | | | |
| Besondere Vorkommnisse | | | | | | | | | | | | | | |